Complete Summary

GUIDELINE TITLE

Practice parameter for the detection of colorectal neoplasms: an interim report (revised).

BIBLIOGRAPHIC SOURCE(S)

Ko C, Hyman NH, Standards Committee of The American Society of Colon and Rectal Surgeons. Practice parameter for the detection of colorectal neoplasms: an interim report (revised). Dis Colon Rectum 2006 Mar;49(3):299-301. [4 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Colorectal neoplasms

GUIDELINE CATEGORY

Prevention
Risk Assessment
Screening

CLINICAL SPECIALTY

Family Practice
Gastroenterology

Internal Medicine
Medical Genetics
Oncology
Pediatrics
Preventive Medicine

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To provide a summary of the Task Force guidelines to serve as an interim updated practice parameter for the detection of colorectal neoplasms

TARGET POPULATION

- People in the United States (U.S.) at average risk for colorectal cancer
- People in the U.S. at increased risk for colorectal cancer (history of adenomatous polyps or colorectal cancer; inflammatory bowel disease; family history of colon cancer, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer)

Note: People with symptoms or signs that suggest the presence of colorectal cancer or polyps fall outside the domain of screening and should be offered an appropriate diagnostic evaluation.

INTERVENTIONS AND PRACTICES CONSIDERED

1. Risk stratification based on personal, family, and medical history
2. Patient education regarding screening options
3. Screening tests, including:
    - Fecal occult blood test (FOBT)
    - Flexible sigmoidoscopy
    - Combined FOBT and flexible sigmoidoscopy
    - Colonoscopy
    - Double-contrast barium enema (DCBE)
4. Genetic counseling and testing in select populations
5. Follow-up of positive screening test
6. Surveillance of patients at increased risk

Note: Computed tomography (CT) colonography and fecal DNA tests were considered but not recommended outside of the research setting.

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

A MEDLINE search of the literature since the 2003 Guideline Report* was accomplished using the keywords "screening, colorectal cancer, fecal, stool, and DNA" with related articles to ensure that new data did not exist to substantively modify the Task Force recommendations. If so, the new evidence is cited.

*Note: This guideline is a partial adaptation of an earlier guideline: Winawer S, Fletcher R, Rex D, Bond J, Burt R, Ferrucci J, Ganiats T, Levin T, Woolf S, Johnson D, Kirk L, Litin S, Simmang C, Gastrointestinal Consortium Panel. Colorectal cancer screening and surveillance: clinical guidelines and rationale. Update based on new evidence. Gastroenterology 2003 Feb;124(2):544-60

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Not stated

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from National Guideline Clearinghouse (NGC) and the American Society of Colon and Rectal Surgeons (ASCRS)*: These guidelines are partially adapted from guidelines published in 2003*: See the NGC summary of the U.S. Multisociety Task Force on Colorectal Cancer guideline, Colorectal cancer screening and surveillance: clinical guidelines and rationale-update based on new evidence.

The Standards Committee has decided to provide a summary of the task force guidelines to serve as an interim updated practice parameter. Two emerging technologies, including fecal deoxyribonucleic acid (DNA) screening and computed tomography (CT) colonography, are discussed at the end of this summary.

General Recommendations

- People with symptoms or signs that suggest the presence of colorectal cancer or polyps fall outside the domain of screening and should be offered an appropriate diagnostic evaluation.
- Screening programs should begin by classifying the individual patient's level of risk based on personal, family, and medical history, which will determine the appropriate approach to screening for that person.
- They should be offered options for screening, with information about the advantages and disadvantages associated with each approach, and should be given an opportunity to apply their own preferences in selecting how they should be screened.
- If the result of a screening test is abnormal, physicians should recommend a complete structural examination of the colon and rectum by colonoscopy (or flexible sigmoidoscopy and double contrast barium enema if colonoscopy is not available).
- Surveillance with colonoscopy should be considered for patients who are at increased risk because they have been treated for colorectal cancer, have an adenomatous polyp diagnosed, or have a disease that predisposes them to colorectal cancer, such as inflammatory bowel disease.
- Health care providers who perform the tests should have appropriate proficiency, and the tests should be performed correctly. To achieve these goals, care systems should establish standards and operating procedures.

- Screening should be accompanied by efforts to optimize the participation of patients and health care providers--both with screening tests and appropriate diagnostic evaluation of abnormal screening test results--and to remind patients and providers about the need for rescreening at recommended intervals.

Recommendations for Average Risk People

- Offer yearly screening with fecal occult blood test (FOBT) using a guaiac-based test with dietary restriction or an immunochemical test without dietary restriction. Two samples from each of three consecutive stools should be examined without rehydration. Patients with a positive test on any specimen should be followed up with colonoscopy.
- Offer flexible sigmoidoscopy every five years.
- Offer screening with FOBT every year combined with flexible sigmoidoscopy every five years. When both tests are performed, the FOBT should be done first.
- Offer colonoscopy every ten years.
- Offer double-contrast barium enema (DCBE) every five years

Recommendations for Increased Risk People

- People with a first-degree relative (parent, sibling, or child) with colon cancer or adenomatous polyps diagnosed at age younger than 60 years or two first-degree relatives diagnosed with colorectal cancer at any age should be advised to have screening colonoscopy starting at age 40 years or 10 years younger than the earliest diagnosis in their family, whichever comes first, and repeated every 5 years.
- People with a first-degree relative with colon cancer or adenomatous polyp diagnosed at age 60 years or older or two second-degree relatives with colorectal cancer should be advised to be screened as average risk persons, but beginning at age 40 years.
- People with one second-degree relative (grandparent, aunt, or uncle) or third-degree relative (great grandparent or cousin) with colorectal cancer should be advised to be screened as average risk persons.

Familial Adenomatous Polyposis

- People who have a genetic diagnosis of familial adenomatous polyposis (FAP), or are at risk of having FAP but genetic testing has not been performed or is not feasible, should have annual sigmoidoscopy, beginning at age 10 to 12 years, to determine if they are expressing the genetic abnormality. Genetic testing should be considered in patients with FAP who have relatives at risk. Genetic counseling should guide genetic testing and considerations of colectomy.

Hereditary Nonpolyposis Colorectal Cancer

- People with a genetic or clinical diagnosis of hereditary nonpolyposis colorectal cancer (HNPCC) or who are at increased risk for HNPCC should have colonoscopy every 1 to 2 years beginning at age 20 to 25 years, or 10 years earlier than the youngest age of colon cancer diagnosis in the family--

whichever comes first. Genetic testing for HNPCC should be offered to first-degree relatives of persons with a known inherited mismatch repair (MMR) gene mutation. It also should be offered when the family mutation is not previously known, but one of the first three of the modified Bethesda Criteria is met.

Surveillance of People at Increased Risk

People with a History of Adenomatous Polyps

- Patients who have had one or more adenomatous polyps removed at colonoscopy should be managed according to the findings on that colonoscopy. Patients who have had numerous adenomas, a malignant adenoma (with invasive cancer), a large sessile adenoma, or an incomplete colonoscopy should have a short interval follow-up colonoscopy based on clinical judgment. Patients who have advanced or multiple adenomas ($\geq$3) should have their first follow-up colonoscopy in three years. Patients who have one or two small (<1 cm) tubular adenomas should have their first follow-up colonoscopy at five years. It is not unreasonable, given available evidence, to choose even longer intervals. However, the evidence is still evolving. Future evidence may clarify the intervals more precisely.
- The timing of the subsequent colonoscopy should depend on the pathology and number of adenomas detected at follow-up colonoscopy. For example, if the first follow-up colonoscopy is normal or only one or two small (<1 cm) tubular adenomas are found, the next colonoscopy can be in five years.

People with a History of Colorectal Cancer

- Patients with a colon cancer that has been resected with curative intent should have a colonoscopy around the time of initial diagnosis to rule out synchronous neoplasms. If the colon is obstructed preoperatively, colonoscopy can be performed approximately six months after surgery. If this or a complete preoperative examination is normal, subsequent colonoscopy should be offered after three years, and then, if normal, every five years.

People with Inflammatory Bowel Disease

- In patients with long-standing, extensive inflammatory bowel disease, surveillance colonoscopy with systematic biopsies should be considered. This applies to both ulcerative colitis and Crohn´s colitis because the cancer risk is similar in both diseases.

Emerging Screening Tests

CT Colonography

- At the time of the consensus panel, the conclusion regarding CT colonography was that the technology was still improving but not yet ready for widespread screening outside the research setting. Since publication of these guidelines, several studies have been performed to investigate the use of CT

colonography for colorectal cancer screening. The majority of these studies still show that further improvements in the technique are required.

Fecal DNA Tests

- The panel acknowledged that screening tests searching for altered DNA in the stool may be a promising approach. Trials measuring the performance of the test in large numbers of average-risk people are needed. No literature since the publication of the 2003 report changes these conclusions.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate screening and diagnostic evaluation of colorectal neoplasms

POTENTIAL HARMS

Not stated

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

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DATE RELEASED

2006 Mar

GUIDELINE DEVELOPER(S)

American Society of Colon and Rectal Surgeons - Medical Specialty Society

SOURCE(S) OF FUNDING

American Society of Colon and Rectal Surgeons

GUIDELINE COMMITTEE

Standards Practice Task Force of the American Society of Colon and Rectal Surgeons

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Task Force Members: Clifford Ko, MD; Neil H. Hyman, MD

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the American Society of Colon and Rectal Surgeons (ASCRS) Web site.

Print copies: Available from the ASCRS, 85 W. Algonquin Road, Suite 550, Arlington Heights, Illinois 60005.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

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